Medicare Prescription Drug, Improvement, and Modernization Act of 2003

THE NEW MEDICARE PRESCRIPTION DRUG BENEFIT: TRUE OUT-OF-POCKET COSTS

Section 1860D-2

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) uses a concept called "true out-of-pocket" (TrOOP for short) that may not be familiar to beneficiaries. The new Medicare drug benefit's standard coverage features a $250 deductible, 25% cost-sharing up to $2250 in total spending and then a coverage gap. The benefit's catastrophic coverage begins when the enrollee reaches $3600 in out-of-pocket spending. ***To count toward this limit, the costs must be truly coming out of the beneficiary's pocket***, with limited exceptions.

Sources of payment for cost sharing that count toward the true out-of-pocket limit:

- The beneficiaries themselves, as long as they are not reimbursed by an insurer,
- Another individual, such as a family member (also as long as they are not reimbursed by an insurer),
- Medicare's cost-sharing assistance for people with low incomes, and
- State Pharmaceutical Assistance Programs.

Sources of payment that do not count:

- An insurer, such as a group health plan (including employers' retiree plans),
- Any supplemental coverage purchased through a Medicare prescription drug plan or a Medicare Advantage plan, and
- Any other third-party payment arrangement.

If a beneficiary is receiving supplemental help from a third-party insurer, the practical effect of the TrOOP will be to delay the start of the catastrophic benefit. Recall that for the standard drug benefit, a beneficiary reaches the $3600 limit when he or she has $5100 in total drug spending. If, for example, a supplemental insurer chooses to "fill in the donut" by paying 75 percent of beneficiaries' costs in the coverage gap, then the catastrophic coverage begins at $13,650 in total spending. In all cases the beneficiary is really paying $3600 at the start of the catastrophic coverage, with Medicare and the supplemental payer picking up the rest.

The Centers for Medicare & Medicaid Services will work with plans and the providers of supplemental coverage to construct a system to coordinate the benefit and track the sources of these cost-sharing payments. In addition, Medicare Part D plans will be required to ask beneficiaries what kind of third-party supplemental coverage (if any) they have. If a beneficiary materially misrepresents what supplemental coverage he or she has, this may be grounds for termination from Part D under the law.